Action Plan in response to the PPO Report into the death of

Mr Floyd Carruthers on 14/06/2021 at HMP Birmingham

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should ensure that prisoners with a pacemaker fitted have a care plan and ongoing monitoring/reviews with links to external cardiology departments.	Accepted	The clinical recording system (Systm1) has been updated with 2 care plan templates for use for patients with a pacemaker - one for initial assessment when they come to prison or when the pacemaker is first fitted and the second for a six-monthly review. These are used for ongoing monitoring and review and includes ensuring previous cardiology monitoring has been obtained. The use of these care plans will be reviewed to ensure completion and have been documented in Healthcare Clinical Governance	Head of Healthcare	February 2022
2	The Head of Healthcare should undertake an audit of blood test requests and results to understand why the blood test results were not recorded in this case, and take the required action to avoid recurrence.	Accepted	An audit has been undertaken and will be presented at Healthcare Clinical Governance in April 2022. The outcomes of this audit will be examined and actions updated accordingly	Head of Healthcare	February 2022

3	The Governor should ensure that all staff are alert to signs of self-neglect and aware of their safeguarding responsibilities under PSI 16/2015.	Accepted	Staff have been briefed through Notice To Staff regarding signs of self-neglect as per PSI 16/2015. The safeguarding policy has been reissued and all managers are responsible for informing staff to be aware of prisoners who fail to maintain their hygiene, leave their cell or carry out basic tasks.	Governor	February 2022
4	The Governor should ensure that there are no unnecessary delays in discharging ambulances.	Accepted	The Orderly Officer and Duty Governors have been informed there should be no delay to any emergency vehicle leaving the prison. This includes ensuring adequate staffing to escort an ambulance in the grounds, adequate staff to accompany the prisoner to hospital, the orderly officer prioritising blue light ambulances and allowing the support orderly officer to maintain the prison's regime and the Duty Governor to be present to provide a signature subject to healthcare advice. Any difficulty locating the Duty Governor should result in escalation to another Governor who can support the escort risk assessment completion.	Governor	February 2022
5	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases: • healthcare staff complete the medical information section of the	Accepted	The Governor has also written to all Duty Governors stating that healthcare advice must be sought and evidenced prior to agreeing cuffing arrangements. This is a repeat recommendation and the Governor has therefore written this as an Operational and Governor's order which will result in investigative action to be taken against any Governor failing to take account of healthcare advice when considering the suitability of cuffing arrangements. This includes	Governor	February 2022

	escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and • authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.		evidencing the consideration of healthcare advice to agree a defensible decision.		
6	The Governor should ensure that a prisoner's custodial status is accurately updated in a timely way, and that there are safeguards in place to prevent a prisoner being held in custody beyond the end of their sentence.	Accepted	Any court failing to provide a written warrant to legally detain an individual will be chased and escalated to a senior manager to pursue with the court. The error linked to written sentence length in the PER now forms part of the management check in the custody department.	Governor	February 2022
7	The Governor should ensure that prison documentation is stored securely and provided promptly when requested during a PPO investigation, in line with PSI 58/2010.	Accepted	All documentation is now drawn from a list in a proactive fashion ready for the PPO's request. Requests are made immediately after a death in custody and CCTV returns are now prompt. If there are concerns about a lack of response from certain departments regarding information requests these are taken immediately to the Head of Safer Custody and then escalated from there to the Governor.	Governor	April 2022